Delegate's Name:_____ Region_____

MISSOURI ASSOCIATION FAMILY, CAREER AND COMMUNITY LEADERS OF AMERICA
Sample Medical Release Form
National Leadership Meeting
Orlando, Florida

I, _____of_____
Parent/Guardian/Spouse Name Address

_____ am the _____of_____
City State ZIP Relation Member's Name

of_____.
City State ZIP

I hereby give my consent, in the event all reasonable attempts to contact me have been unsuccessful, for immediate medical treatment as required in the judgment of the attending physician while_____ is absent from home _____ to _____.

* * * * * * * * * * *

Date of Birth:_____ Social Security Number:_____

Parent/Guardian/Spouse Phone Number(s):
Work:_____ _____
Home:_____ _____

Family Physician:_____ Family Dentist:_____

Address:_____ _____
Street Street

_____ _____
City State ZIP City State ZIP

Phone:_____ _____ _____ _____
Work Home Work Home

Medical Insurance Company:_____Policy Number:_____

Name of Insured:_____

The following information is needed by any hospital or practitioner not having access to a medical history:

Allergies:_____

Medication being taken:_____

Date of last tetanus shot:_____

Physical impairments:_____

Other pertinent facts to which physician should be alerted:_____

_____

(over)

If Spouse or Parent cannot be reached in case of emergency, call:

_____ _____

First Choice Name Area Code Phone

_____ _____

Second Choice Name Area Code Phone

In a medical emergency, I consent to the local/state advisor or appointed agent, his/her or their discretion in using, taking, arranging for, or consenting to the procedures or treatment.

I agree to indemnify and hold harmless the Missouri Association of Family, Career and Community Leaders of America, the individual members, agents, employees and representatives thereof, for any and all claims, demands, actions, rights of action, and/or judgments by or on behalf of the above named member arising from or on account of said procedures and/or treatment rendered in good faith and according to accepted medical standards.

I assume the total financial responsibility for the above named member and will not hold the Missouri Association of Family, Career and Community Leaders of America responsible in the event of a medical emergency.

_____ _____

Signature of Spouse or Parent/Guardian Date

_____

Social Security number AND Birthdate of Spouse or Parent/Guardian

(will only be used if emergency medical treatment is required)

(This is a sample form that can be used on by the local chapter. Please refer to local school district policies on the use of health and travel permission forms. Do not send health forms to the state advisor.)